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**EQUITABLE AND SUSTAINABLE WASH SERVICES:
FUTURE CHALLENGES IN A RAPIDLY CHANGING WORLD**

Prioritizing equitable access to sanitation for vulnerable groups: Lessons from SSH4A programme in 5 countries

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Introduction

Access to sanitation by vulnerable groups (women, the poor, the elderly and PWDs) is a challenge in most developing countries. A baseline study undertaken by SNV in 2014, at the beginning of The Sustainable Sanitation and Hygiene For All (SSH4A) implemented in Kenya (KE), Nepal (NP), Zambia (ZB), Tanzania (TZ) and Ethiopia (ET) showed that in Kenya, Tanzania, Ethiopia and Zambia, open defecation (OD) in women headed households was on average higher by 10% and in the poorest wealth quintile it was on average higher by 60% as compared to OD in all HHs combined (baseline report 2014).

Interventions

SNV supported local governments to adopt an area wide approach to service delivery for rural sanitation and hygiene in the phase 1 of SSH4A project (2014-2017). The approach provided stakeholders (Govt and non Govt) with the opportunity to discuss the needs of the different geographical areas (remote) and adopt mechanisms that increased vulnerable groups (VGs) participation, influence and access to sanitation. Four interventions undertaken were: (1) Local leaders were supported to engage VGs and discuss their needs and address their barriers. Leaders resolved to always invite VG household heads to attend sanitation meetings and VGs household heads take up leadership positions in sanitation committees, (2) Outreach activities to increase participation and voice in sanitation activities. In Kenya and Tanzania, female Community Health promoters (CHPs) were trained on how to promote sanitation and hygiene (S&H) options in the community targeting the VGs. In Nepal, Female Community Health Volunteer (FCHV) affiliated to government health posts were identified and targeted as the most reliable source of communication. In Zambia, mood meters were introduced to enable people who cannot read and write to participate in scoring on sanitation progress, (3) Community promoters and entrepreneurs were supported to roll out and demonstrate informed choice sanitation options in the communities. In Ethiopia, disability potty chairs were developed and provided by the community promoters to the needy PWDs. In Tanzania, wooden pedestal stools for the elderly and PWDs were designed and sanitation entrepreneurs trained to produce and sell the technology options and (4) Community sanitation networks to mobilise, monitor and report on sanitation progress were introduced/strengthened in Ethiopia and Tanzania. In Ethiopia, the health development Army (HDA) consisting of six households with a leader were given further trainings. In Tanzania, 10 households (Mabalozi) were reconstituted and upgraded into Jirani Sanitation Groups (JSGs) each with a leader.

Results of phase 1 of the SSH4A project (2014-2017)

VGs participation and influence on sanitation and hygiene activities increased

Women and the poor participation in village and sub village levels meetings increased from no participation to participating and influencing of decisions. Participation of the women and the poor was higher because communities were relatively more open to discussing issues of women and the poor in meetings. In Tanzania,

VGs lobbied and accessed trees and grass from the village forests free of charge to construct toilets. In Zambia, Sanitation Action Groups (SAGs) in chiefdoms provided female headed households with labour to construct toilets and women were appointed as community champions. On the other hand, PWDs participated in meetings but did not influence decisions. Communities were unable to overcome the stigma and openly discuss issues of disabled family members.

Increased access to appropriate technology options

There was increased availability and access to technology options by the VGs in the project areas. In Tanzania, wooden pedestals produced by the trained carpenters became available in every village. In Ethiopia commode chairs made locally were available and family members bought for the PWDs. In Zambia, raised seats and rails were introduced and became popular. An innovative method of activating demand where sessions were held in family settings triggered shame on the part of the family members leading to increased purchasing of the wooden stools for PWDs and the Elderly

Increased access to sanitation

OD% in VG headed households declined significantly across the 5 countries. In Ethiopia and Nepal the decline was from as high as 97% to 7% and from 82% to 4%, respectively. Access to improved toilets increased significantly across the 5 countries. In Ethiopia and Nepal, the increase was from as low as 0% to as high as 89% and from 9% to 91%, respectively. The increase was lowest in Kenya where it ranged from 6% to only 37%. Across the VGs, the average increase in access to improved toilets was higher for women headed (73%) and least in poor headed households (64%).

Lessons learned and conclusions

Whereas access to sanitation by VGs significantly increased, OD was not eliminated and VGs access to improved toilets fell below 100%. These results show that local support mechanisms (family, community etc) are not sufficient to enable all VGs attain ODF and climb up the sanitation ladder. Structured government led pro VG mechanisms including smart subsidies/innovative mechanisms are required to complement the local level initiatives. Poor households that are in most cases resource poor require more special attention.

Getting PWDs to influence decisions on rural Sanitation and Hygiene programmes was a challenge. Even for community level sessions there were structural and traditional barriers that limited their ability to effectively participate and influence decisions. Invitation letters to attend meeting were sent but structured mechanisms to enable the PWDs travel and attend the meetings were limited. Sanitation requirements for PWDs and especially those with physical handicaps are not simple and most families end up not investing in them.

To cater for various impairments of persons with disabilities, there is a need to adopt a variety of innovative intervention tools such as house to house demand activation methods that target families. Talking to PWDs and the elderly in awareness meetings creates interest but do not translate into purchases because most of the PWDs and the elderly do not have the resources to make the purchases. Family discussions that generate shame prompt family members to commit and purchase sanitation facilities for PWDs and the elderly in the families.

Use of pictures and illustrations for people with hearing or speech impairments and use of radio for the visually impaired worked well and ought to be upscaled. Mood meter/chart to measure sanitation progress was found to be very appealing and appropriate for the rural folks who did not know how to read and write in Zambia. The mood meter enabled individuals with low literacy levels to comprehend the progress measurement system and score.

Working with women and strengthening their participation and influencing decisions proved to be effective. However, triggering of men to support resource allocation was found to be a requirement because men still determined which resources and the amount to be invested in sanitation facilities.

References

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